APPEAL NO. 990549

This appeal arises under the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). On February 1, 1999, a contested case hearing (CCH) was held. With respect to the issues before him, the hearing officer determined that appellant/cross-respondent (claimant) did not sustain a compensable cervical injury on _____, and did not have disability, and that the first certification of maximum medical improvement (MMI) and impairment rating (IR) of Dr. O did not become final pursuant to Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.5(e) (Rule 130.5(e)).

Claimant appealed the findings regarding no cervical injury and disability, contending the medical evidence showed otherwise and that he had disability from April 28, 1998, through the date of the CCH. Claimant requests reversal of those two determinations. Respondent/cross-appellant (carrier) filed a conditional appeal, contending that Dr. O's certification of MMI and zero percent IR became final by operation of Rule 130.5(e). Carrier also filed a response to claimant's appeal, urging affirmance on those issues.

DECISION

Affirmed on all issues.

As the claimant noted in his opening statement at the CCH, "this case actually begins before the date of injury." Claimant had spinal surgery in the form of a fusion at the C5-6 and C6-7 level on January 26, 1993, due to nonwork-related reasons. Dr. V was claimant's surgeon and treating doctor for this injury and continued to see claimant through the spring and summer of 1993. (The medical records will be summarized later.) Claimant returned to work sometime after the surgery and testified that he had been employed as a millwright for a tire manufacturer (employer) since 1984. The parties stipulated that claimant sustained a compensable right shoulder injury on _____, when a tire fell off a conveyor, striking claimant in the head and on the right shoulder. Claimant saw Dr. O, who is described as the company doctor, but apparently missed no time from work. Claimant filed a report of accident on September 20, 1993, alleging a "right arm & head" injury. (Apparently because no time was lost, no claim was set up with the Texas Workers' Compensation Commission (Commission) until September 1998.) Claimant consulted with both Dr. O and Dr. V about the injury and how it might have affected the cervical spinal fusion. Dr. O prepared a Report of Medical Evaluation (TWCC-69) certifying MMI on September 27, 1993, with a zero percent IR, in latter 1993. Dr. V apparently last saw claimant on April 18, 1994, for this incident. Between April 1994 and February 1998, claimant received no specific treatment for his neck or shoulder and was seen by Dr. T for other medical matters. Claimant testified that between latter 1993 and early 1998 he continued to have pain in his neck but that it was bearable. In February 1998 claimant contracted pneumonia or some sort of respiratory infection with heavy coughing. At about this time, claimant said that his neck pain became progressively worse and that Dr. T took him off work on April 28, 1998. Claimant had additional cervical spinal fusion surgery on July 10, 1998, by Dr. M Claimant spoke with someone at the Commission about his case

on October 12, 1998, and was told that carrier considered Dr. O's first certification of MMI and IR filed in latter 1993 final. Claimant testified that he never received that report until two days before the benefit review conference (BRC) in December 1998 and disputed the IR on October 12, 1998, and at the BRC.

The medical records show that claimant had cervical surgery at C5-6 and C6-7 in January 1993 due to shoulder numbness and right thumb discomfort, and that claimant was advised of the risks of that surgery, including a lack of healing. A May 17, 1993, note by Dr. V shows "minimal motion at C6-7" and concludes:

> Only if he were to have increasing neck discomfort that he could not deal with would I recommend any tomograms under flexion and extension. Only then would we consider the aspect of posterior neck fusion if he were having lots of residual symptoms.

In a report dated July 12, 1993, Dr. V noted claimant was asymptomatic and x-rays showed "good incorporation." Claimant sustained a compensable injury on _____, when a tire fell on his head and right shoulder. Claimant was seen by Dr. O, who, in an Initial Medical Report (TWCC-61) dated September 22, 1993, diagnosed a supraspinatus muscle sprain/strain with no evidence of bony abnormality. That finding was repeated in a Specific and Subsequent Medical Report (TWCC-64) of a September 27, 1993, visit. Subsequently, Dr. O completed a TWCC-69 certifying MMI on September 27, 1993, with a zero percent IR. On December 13, 1993, claimant saw Dr. V, who noted the August 1993 accident, complaints of increased symptoms in claimant's neck and commented on x-rays as follows:

> This shows excellent position of C5/6, incorporation of the graft, and there appears to be motion at C6/7 with graft fracture. There has not been significant settling at this point, and there is no particular nerve root compromise.

Claimant saw Dr. V again on April 18, 1994, where Dr. V notes it has been 15 months since claimant's cervical surgery, that claimant "is essentially asymptomatic per his report," that claimant "is working regular duty. He is doing very heavy work" and that claimant is encouraged "not to do any overhead lifting or looking up . . . ."

Between 1994 and early 1998, claimant received no treatment for his neck complaints. A report from Dr. JO dated February 24, 1998, recites Dr. V's cervical surgery "several years ago," that claimant "did relatively well" and that:

> More recently he has been bothered by symptoms of an upper respiratory infection/flu. This has caused him to have a bad cough. In so doing, he thinks that his disks might now be "loose." This is because he is beginning to experience many of the symptoms that he had preoperatively. This included numbness and tingling in both arms, as well as pain.

That report noted that claimant had wanted to see Dr. V but that Dr. V had moved to another distant city. Claimant was seen by Dr. T, who, in a report dated February 26, 1998, noted tha claimant has "Sjogren's syndrome" and commented:

> He was in his usual state of adequate health when he recently awoke with severe neck pain and fever. He could not ambulate. Every time he sat up, he passed out. He has pain which radiates down both arms to the level of the hands. His pain was so severe that he came to the emergency room. MRI was basically indicative of no significant change other than previous surgical intervention. He has no evidence of fusion, failure or other difficulties although he does have a C4-C5 disc which is of questionable significance.

Elsewhere in that report, Dr. T comments "acute onset of neck pain of uncertain etiology." In a consultation dated March 3, 1998, Dr. G writes about the August 1993 tire incident:

> He had a 3-4 week time period of neck stiffness and pain that resolved with restricted activities and restricted work duty. He was seen by his surgeon in (City) at that time, and the surgeon stated that it appeared the C6-C7 fusion had been broken. This seemed to resolve without any symptomatology until the last few months. He states that in the last few months the bilateral neck pain has worsened, and recently, a few days prior to admission, he had a high fever, I believe some coughing and congestion, and the neck pain got seriously worse.

Dr. G concluded:

> I feel that the most likely etiology is the C6-7 pseudoarthritis. My best guess is that he had a pseudoarthrosis there, with some stability from the fibrous union, but with his pneumonia or whatever he has had, he was coughing a lot and he probably broke this loose with that, and since that time he has developed this very significant neck pain.

Claimant had a cervical fusion to relieve his neck symptoms on July 10, 1998, by Dr. M.

> In evidence is an undated "To Whom It May Concern" note from Dr. V, stating:
>
> [Claimant] had fusion of his cervical spine done at C5-6 and C6-7 in January 1993. The patient had returned to work. He had a blow to the head with a tire that caused significant increase of pain in his cervical spine and the fusion appeared to have either fractured or was incomplete.
>
> Thus, it appears that the incident associated with the tire striking his head not only increased his pain but was instrumental in his continued neck pain. I concur with his request for further treatment as related to this incident.

In another similar note dated October 19, 1998, Dr. V writes:

[Claimant] is a patient that had a previous disk excision and fusion by myself in 1993. The patient has an underlying diagnosis of Sjogren's and developed what appears to be a pseudoarthrosis of the C6-7 level with subsequent spondylosis and neural entrapment. He appeared to have what appeared to be a solid fusion at C5-6. He has developed further bulging at C4-5. I do consider the pseudoarthrosis and related spondylosis noted in his cervical spine to be related to his previous work injury as this is the same area as outlined previously. Thus, further reparative surgery in this area would be related to his original work injury.

In appealed findings, the hearing officer found:

FINDINGS OF FACT

5. Between May of 1994 and February 1998, there is little or no documented medical evidence showing treatment for the Claimant's cervical spine or neck.

6. The evidence is insufficient to establish that the work related injury on _____, caused damage or harm to the Claimant's cervical spine.

Claimant appeals those findings stating that he had been under the care of Dr. T who "continued to observe my cervical problems" and mentioning Dr. V's reports. While it is true that claimant was seeing Dr. T for other medical problems the reports suggest that claimant received a compensable injury on _____, but that he did not see Dr. O until some weeks later, that both Dr. O and Dr. V considered claimant's January 1993 cervical surgery and that claimant returned to work for four and one-half years without incident until he had some type of respiratory infection with heavy coughing in February 1998 which even claimant thought might have caused his discs to be "loose." The hearing officer's finding that there was insufficient evidence to establish that the August 1993 work injury caused claimant's current problems is supported by the evidence. We have frequently noted that Section 410.165(a) provides that the hearing officer, as finder of fact, is the sole judge of the relevance and materiality of the evidence as well as the weight and credibility that is to be given the evidence. It was for the hearing officer, as trier of fact, to resolve the inconsistencies and conflicts in the evidence. Garza v. Commercial Insurance Company of Newark, New Jersey, 508 S.W.2d 701 (Tex. Civ. App.-Amarillo 1974, no writ). This is equally true regarding medical evidence. Texas Employers Insurance Association v. Campos, 666 S.W.2d 286 (Tex. App.-Houston [14th Dist.] 1984, no writ).

Regarding disability, since the claimant's inability to obtain and retain employment was due to claimant's cervical condition after February 1998, rather than the compensable injury, claimant did not have disability as defined in Section 401.01(16). Regarding carrier's assertion that Dr. O's 1993 first certification of MMI and zero percent IR is final under Rule 130.5(e), there is no evidence, or very little evidence, that that report was sent to either the claimant or to the Commission. Claimant adamantly testified that he did not receive the

report and there is no evidence that he did. Apparently the August 1993 injury was treated as a no lost time injury and the Commission did not establish a file on that injury until September 1, 1998, when claimant filed his Employee's Notice of Injury or Occupational Disease & Claim for Compensation (TWCC-41). As the hearing officer noted, it would have been difficult to marry up the TWCC-69 with this injury if no file had been established. We hold the hearing officer's finding that claimant did not receive notice of Dr. O's report until October 12, 1998, to be supported by the evidence.

Upon review of the record submitted, we find no reversible error and we will not disturb the hearing officer's determinations unless they are so against the great weight and preponderance of the evidence as to be clearly wrong or unjust. In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951). We do not so find and, consequently, the decision and order of the hearing officer are affirmed.

_____
Thomas A. Knapp
Appeals Judge

CONCUR:

_____
Tommy W. Lueders
Appeals Judge

_____
Elaine M. Chaney
Appeals Judge